

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02844

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County DorchesterCity or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 Years

Hospital, institution, or street address where death occurred:

303 West End Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)Street No. 303 West End Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Mary C. Andrews

## 3.(b) Social Security Number

-

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife Isaac T. Andrews(Deceased)

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec. 21, 1854.

8. AGE:

Years

Months

Days

If less than one day

90225

hrs.

min.

9. Birthplace Andrews, Dor. Co., Maryland.  
(Town, county, and state)10. Usual occupation Domestic11. Industry or business Home

FATHER

12. Name Benjamin Hart13. Birthplace Maryland

MOTHER

14. Maiden name Catherine Insley15. Birthplace Maryland.16. Informant T. B. AndrewsAddress Cambridge, Maryland.17. Burial Date thereof March 18, 1945  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Greenlawn CemeteryLocation Cambridge, Maryland.18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.19. 3-17- 19 45 John M. J. M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 19 45 at 9:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 28 19 45 to Mar 6 19 45and that I last saw him alive on Feb. 28 19 45Immediate cause of death Proemia

DURATION

3 wksDue to Cerebral - Focal2 yr.Due to vascular brain

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations noneDate of op. noneAutopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? X (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury gun Injured at work?23. SIGNATURE John M. J. M.D.

M. D. or other

Address Cambridge, Md Date signed 3-17- 19 45

RECEIVED  
MAR 19 1945  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 952

## CERTIFICATE OF DEATH

02845

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County... DorchesterCity or town... Cambridge  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

405 Race St.How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... DorchesterCity or town... Cambridge  
(If outside city or town limits, write RURAL and give nearest town)Street No... 405 Race St.

(If rural, give LOCATION)

2.(a) If veteran, name war -

## 3. (a) FULL NAME

Florence Robbins Applegarth

## 3. (b) Social Security Number

-4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Married5. (b) Name of husband or wife Raymond T. Applegarth6. (c) If alive, give age 56 years7. Birth date of deceased (mo., day, yr.) Jan. 7, 1891.8. AGE: Years 54 Months 2 Days 21 If less than one day  
.....hrs. ....min.9. Birthplace Cambridge, Dor. Co., Maryland.  
(Town, county, and state)10. Usual occupation Domestic11. Industry or business Home12. Name Joseph E. Robbins13. Birthplace Maryland14. Maiden name Ida V. James15. Birthplace Maryland16. Informant Raymond T. ApplegarthAddress 405 Race St., Cambridge, Md.17. Burial Date thereof Mar. 30, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Dorchester Memorial ParkLocation Cambridge, Maryland.16. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.4-3-45 John M. ...

19. (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1945 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

MARCH 27, 1945 to MARCH 28, 1945and that I last saw her alive on MARCH 28, 1945Immediate cause of death RIGHT CEREBRAL HEMORRHAGE

## DURATION

14 Hours.Due to HYPERTENSIVECARDIOVASCULAR DISEASE?Due to RESIDUAL RT. HEMIPLEGIAOther conditions 4 mos.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: NO.

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [Signature]Address Cambridge, Md.Date signed 3/29/45

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APR 9 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02846

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County DorchesterCity or town Rural (Salem)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? -

Hospital, institution, or street address where death occurred:

Home (Salem)How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Rural (Salem)  
(If outside city or town limits, write RURAL and give nearest town)Street No. Salem  
(If rural, give LOCATION)2.(a) If veteran, name war -

## 3. (a) FULL NAME

Della Wilson LeCompte Baumgartner

## 3. (b) Social Security Number

-

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Otto M. Baumgartner6. (c) If alive, give age - years7. Birth date of deceased (mo., day, yr.) May 18, 1889.

## 8. AGE:

Years 55Months 9Days 15

If less than one day

hrs. min.

9. Birthplace Salem, Dor. Co., Maryland.  
(Town, county, and state)10. Usual occupation Domestic11. Industry or business Home12. Name Charles E. LeCompte13. Birthplace Maryland14. Maiden name Helen Pusey15. Birthplace Maryland16. Informant Otto M. BaumgartnerAddress Salem, Maryland.17. Burial Date thereof Mar. 5, 1945.  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Dorchester Memorial Park.Location Cambridge, Maryland.18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.19. 3/6/45 19 45 John M. Mays, Jr.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1945 at 9: A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1944 to March 3, 1945and that I last saw him alive on 19

Immediate cause of death

Cerebral Hemorrhage

DURATION

1/2 hourDue to Essential Hypertension1 yr. +

Due to

Other conditions

Probable early  
Parkinson's Syndrome.  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William C. Harrison MD  
Henlock Md. M. D. or other 3/6/45  
Address Date signed

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MAR 12 1945  
BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 488

## CERTIFICATE OF DEATH

02847

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County DorchesterCity or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)Street No. 14 Mare Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Rosie Etta Blake

## 3.(b) Social Security Number

4. Sex

female

5. Color or race

colored

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife Stephen Blake

7. Birth date of deceased (mo., day, yr.)

March 27 18906.(c) If alive, give age 57 years

8. AGE:

Years

Months

Days

If less than one day

541126

hrs.

min.

9. Birthplace

Bucktown Dorchester Md  
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

MOTHER FATHER

12. Name

Beady Camper

13. Birthplace

Bucktown Dorchester Co Md

14. Maiden name

Leah Johnson

15. Birthplace

Dorchester Co Md

16. Informant

Helen Risketto

Address

Federalburg Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

3-25-45  
(month) (day) (year)

Cemetery or crematory

Cemetery

Location

Cambridge Md

18. Funeral director

Levin A. Bayneum

Address

Cambridge Md

19.

(Date rec'd by registrar)

3-24-45 John Mace Jr. Md.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1945, at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 25 1945, to March 23 1945,  
and that I last saw him alive on March 23 1945.

Immediate cause of death

Cerebral Hemorrhage

DURATION

4 hrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Carroll M. St. Clair Md

M. D. or other

Address

Date signed 3-25-45

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-01

## CERTIFICATE OF DEATH

02848

Reg. Dist. No. 116

### 1. PLACE OF DEATH:

County Dorchester  
City or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Cambridge - Maryland Hospital, Inc

How long in hospital or institution?

1 day

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester

City or town East new market  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Baby Boy Bramble

### 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) March 8, 1945 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 1 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Mid. Cambridge, Dorchester  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

FATHER 12. Name Marcus C. Bramble

13. Birthplace Mid. Washington Thomas

MOTHER 14. Maiden name Mid. Washington Thomas

15. Birthplace Mid. Washington Thomas

16. Informant Marcus C. Bramble

Address East new market

17. Burial Date thereof Mar 9 1945  
(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location East new market

18. Funeral director F.B. Williams & Sons

Address East new market

19. 3-9- 19 45 John Macph. Md  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 19 45 at 3:20 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8 19 45 to March 9 19 45

and that I last saw him alive on March 8 19 45

Immediate cause of death Respiratory failure

Due to Inter-cranial hemorrhage

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations None Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Eldridge H. Webb M.D. or other \_\_\_\_\_

Address Cambridge Md Date signed 3-9-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.



RECEIVED

RECEIVED

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MAR 19 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-20

## CERTIFICATE OF DEATH

02849

Reg. Dist. No. 169

## 1. PLACE OF DEATH:

County OrchesterCity or town Bishop's Head  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? all of lifeHospital, institution, or street address where death occurred: —How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County OrchesterCity or town Bishop's Head  
(If outside city or town limits, write RURAL and give nearest town)Street No. —  
(If rural, give LOCATION)2.(a) If veteran, name war —

## 3. (a) FULL NAME

Philip Lee Bramble

## 3. (b) Social Security Number

## 4. Sex

male

## 5. Color or race

white

## 6.(a) Single, married, widowed, or divorced

single

## 6.(b) Name of husband or wife

## 7. Birth date of

deceased (mo., day, yr.)

Feb 5-19456.(c) If alive, give age — years

## 8. AGE:

Years

Months

Days

If less than one day

XX27

hrs.

min.

## 9. Birthplace

Cambridge, Md  
(Town, county, and state)

## 10. Usual occupation

none

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Hubbard C. Bramble

## 13. Birthplace

Md

## 14. Maiden name

Ida Pauline Blodsworth

## 15. Birthplace

Md

## 16. Informant

Hubbard C. Bramble

## Address

Bishop's Head Md

## 17.

Burial  
(Burial, cremation, or removal. Which?)Date thereof Mar 6, 1945  
(month) (day) (year)

## Cemetery or crematory

St. Thomas Cemetery

## Location

Bishop's Head, Md.

## 18. Funeral director

LeCompte's Funeral Service

## Address

Cambridge, Md

## 19.

3/6  
(Date rec'd by registrar)

## 19.

45 Wilford & Pritchett  
Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 1945, at 3 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

— 19—, to — 19—and that I last saw h. — alive on — 19—

Immediate cause of death

DURATION

Congenital Malformation  
Due to J. HeartDue to —Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations

— Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) —Means of Injury —Injured at work? —

23. SIGNATURE

J. K. Shriver, Dep. Med. Exam.  
M. D. or otherAddress Cambridge Md Date signed Mar 6/45

CERTIFICATE OF DEATH

RECEIVED  
APR 7 1945  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 302

## CERTIFICATE OF DEATH

02850

Reg. Dist. No. 116

1. PLACE OF DEATH:  
County..... **Dorchester**  
City or town..... **Cambridge**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... **2 yrs. 1 mon. 9 days**  
Hospital, institution, or street address where death occurred:  
**Eastern Shore State Hosp.**  
How long in hospital or institution?..... **2 yrs. 1 mon. 9 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... **Maryland** County..... **Talbot**  
City or town..... **St. Michael's**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3.(a) FULL NAME  
**Oscar Anderson Bryan**

3.(b) Social Security Number

none

4. Sex **Male** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Single**

8.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) **Jan. 2 1881** 6.(c) If alive, give age..... years

8. AGE: Years **64** Months **2 m** Days **8** If less than one day..... hrs. .... min.

9. Birthplace..... **St. Michael's Talbot Co. Md.**  
(Town, county, and state)

10. Usual occupation..... **Laborer**

11. Industry or business.....

FATHER 12. Name..... **James Anderson Bryan**  
13. Birthplace..... **unknown**

MOTHER 14. Maiden name..... **Annie Rebecca Jones**  
15. Birthplace..... **unknown**

16. Informant..... **Hospital records**  
Address..... **Cambridge Maryland**

17. **Burial** Date thereof..... **Mar 13 1945**  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory..... **Oliver Cemetery**  
Location..... **St. Michael's, Md.**

18. Funeral director..... **Newnam & Harrison**  
Address..... **St. Michael's, Md.**

19. **3-10-** 19 **45** **John Massie, Jr. M.D.**  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **March 10** 19 **45** at..... **12.35 PM**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **February 1** 19 **43** to **March 10** 19 **45** and that I last saw him alive on **March 10** 19 **45**

Immediate cause of death.....  
Cerebral Hemorrhage 18 hrs  
Due to.....  
Cerebral Arteriosclerosis 4 yrs.  
---Hypertensive Cardiovascular Dis.  
Due to and  
Hemiplegia  
Other conditions Latent syphilis unknown  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?..... (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury..... Injured at work?

23. SIGNATURE.....  
**Grace M. Branscombe M.D.** M. D. or other  
Address..... **Cambridge Md.** Date signed **3/10/45**

CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS

CITY OF BOSTON

DECEASED

AGE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

SEX

DATE OF BIRTH

NAME

RESIDENCE

Signature of Registrar

DATE

PLACE

TIME

RECEIVED

MAR 19 1945

BUREAU V.S.

MASSACHUSETTS DEPARTMENT OF HEALTH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02851

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County... Dorchester  
 City or town... Rural--Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
Life  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Cambridge RFD # 1  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Dorchester  
 City or town... Rural--Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... Cambridge RFD # 1  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

Vivian Carroll

## 3. (b) Social Security Number

4. Sex... Male  
 5. Color or race... White  
 6.(a) Single, married, widowed, or divorced... Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)... July 11, 1873.  
 8.(c) If alive, give age... years

8. AGE: Years... 71 Months... 8 Days... 2  
 If less than one day... hrs. ... min.

9. Birthplace... Cambridge, Dor. Co., Maryland.  
 (Town, county, and state)

10. Usual occupation... Farmer  
Dirt

11. Industry or business

12. Name... Thomas K. Carroll13. Birthplace... Maryland14. Maiden name... Margaret H. Carroll15. Birthplace... Maryland.16. Informant... Miss Nellie CarrollAddress... RFD # 1, Cambridge, Md.

17. Burial... Burial Date thereof... Mar. 16, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Old Trinity CemeteryLocation... Church Creek, Maryland.18. Funeral director... LeCompte's Funeral ServiceAddress... Cambridge, Maryland.

19. 3-16-45 John M. ...  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... March 13, 1945 at 5:P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 16 1945 to Mar. 13 1945  
 and that I last saw him alive on March 13 1945

Immediate cause of death

Chronic Myocarditis  
 Due to...  
 Due to...  
 Other conditions... Arteriosclerosis

## DURATION

8-10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

J. K. Shriver, M.D.Address... Cambridge, Md. Date signed Mar. 14, 1945



RECEIVED

MAR 19 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02852

Reg. Diat. No. 116

1. PLACE OF DEATH:  
 County..... Dorchester  
 City or town..... Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 2 days  
 Hospital, institution, or street address where death occurred:  
211 Cedar St.  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County..... Dorchester  
 City or town..... Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 152 Washington St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME..... Infant Cephas  
 3. (b) Social Security Number.....

4. Sex..... female  
 5. Color or race..... colored  
 6. (a) Single, married, widowed, or divorced..... single  
 8. (b) Name of husband or wife..... X  
 7. Birth date of deceased (mo., day, yr.)..... March 27, 1945  
 8. AGE: Years..... X Months..... X Days..... 2 If less than one day..... hrs. .... min.

9. Birthplace..... Cambridge, Md.  
 (Town, county, and state)  
 10. Usual occupation..... none  
 11. Industry or business..... X  
 12. Name..... Henson Waters  
 13. Birthplace..... Maryland  
 14. Maiden name..... Geneva Cephas  
 15. Birthplace..... Maryland

16. Informant..... Geneva Cephas  
 Address..... 152 Washington St. Cambridge, Md.  
 17. Burial Date thereof..... 3/31/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Bethel Cemetery  
 Location..... Cambridge Md  
 18. Funeral director..... Levis H. Baynes  
 Address..... Cambridge Md  
 19. 3/31/45 19. 45 John Mace  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 29 1945 9-30 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... X..... 19..... to..... X..... 19.....  
 and that I last saw h..... X..... alive on..... X..... 19.....  
 Immediate cause of death..... Convulsions  
 Due to..... Injury to brain during birth.  
 Due to.....  
 Other conditions..... X  
 (Include pregnancy within 3 months of death)

DURATION  
1 hr.

Major findings of operations.....  
 Date of op. ....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?  
 23. SIGNATURE..... J. H. Shriver, Dep. Med. Exam.  
 Address..... Cambridge, Md. Date signed..... Mar. 29/45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

APR 9 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

## CERTIFICATE OF DEATH

02853

Reg. Dist. No. 110

## 1. PLACE OF DEATH:

County DorchesterCity or town Williamsburg  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

River Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Williamsburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. River Road  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Charles H. Coulbourne

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Clara Hurlock Coulbourne7. Birth date of deceased (mo., day, yr.) January 27, 18588. (c) If alive, give age 77 years8. AGE: Years 87 Months 1 Days 15 If less than one day  
.....hrs. ....min.9. Birthplace Dorchester County, Maryland  
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farm12. Name Daniel Coulbourne13. Birthplace Dorchester County, Maryland14. Maiden name Lelia Frazier15. Birthplace Dorchester County, Maryland16. Informant Mrs. Charles H. CoulbourneAddress Williamsburg, Maryland, R.F.D.17. Burial Date thereof March 15 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rock Creek CemeteryLocation Federalsburg, Maryland18. Funeral director J. F. Edmington & SonAddress Federalsburg, Maryland19. March 15-45 Charles W. Hastings  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1945, at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....

DURATION

Chronic Myocarditis 3-4 yrs

Due to.....

Atherosclerosis 3-4 yrs

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Shriver, Dep. Med. Exam.Address Cambridge, Md. Date signed Mar 13/45

RECEIVED  
APR 5 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82-0

02854

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH: Dorchester  
 County Cambridge  
 City or town Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Cambridge Md. Hospital  
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Dorchester  
 City or town Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 408 Race St.  
 (If rural, give LOCATION)  
 2(a) If veteran, name war none

3. (a) FULL NAME Bessie Z. Graham

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Creamer Graham  
 6. (c) If alive, give age 60 years  
 7. Birth date of deceased (mo., day, yr.) June 11 - 1894  
 8. AGE: Years 50 Months 9 Days 17 It less than one day hrs. 62 min.

9. Birthplace Caroline Co.  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Marion B. Taylor

13. Birthplace Caroline Co.

14. Maiden name Ann H. Sweeney

15. Birthplace Caroline Co.

16. Informant Mrs. Clara Cook

Address Cambridge, Md.

17. Burial Date thereof Mar 30 - 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Dorchester Memorial Park

Location Cambridge, Md.

18. Funeral director Harriet R. Thomas

Address Cambridge, Md.

19. 3-30- 19 45 John Macbeth  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 28 19 45 at 12:05 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27 19 45 to March 28 19 45  
 and that I last saw him alive on March 28 19 45

Immediate cause of death Cerebral Hemorrhage DURATION 36 hours

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clairidge H. H. H. M. D. or other

Address Cambridge, Md. Date signed 3-29-45



RECEIVED BY THE BUREAU OF HEALTH

CERTIFICATE OF HEALTH

RECEIVED BY THE BUREAU OF HEALTH

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RECEIVED  
APR 2 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

02855

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County DorchesterCity or town Church Creek  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Sarah Henson

4. Sex

female

5. Color or race

col

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

John Henson

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age \_\_\_\_\_ years

1942

8. AGE:

Years

Months

Days

If less than one day

63

hrs.

min.

9. Birthplace

Church Creek Dor Co Md  
(Town, county, and state)

10. Usual occupation

Homemaker

11. Industry or business

FATHER  
MOTHER

12. Name

George Cornish

13. Birthplace

Dorchester Co Md

14. Maiden name

Marjorie Graham Henry

15. Birthplace

Dorchester Co Md

16. Informant

Mary GrahamAddress 116 Caroline St Ball, Md

17.

(Burial, cremation, or removal. Which?)

Date thereof March 26 1941  
(month) (day) (year)

Cemetery or crematory

Church Creek Md

Location

Church Creek Md

18. Funeral director

Lewis Baynes

Address

Cambury Maryland

19.

(Date rec'd by registrar)

19

45John Macgregor  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Church Creek  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1941, at 3:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 12 1941 to March 16 1941and that I last saw him alive on March 16 1941

Immediate cause of death

Pulmonary Edema  
Acute / Sublethal  
Ch. Myocarditis

DURATION

10 days  
4 weeks  
1.5 months

Due to

Other conditions

Hypertension

(Include pregnancy within 6 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Carroll M. St. Clair  
M. D. or other

Address

Date signed 3-19-41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlen St., Baltimore

## CERTIFICATE OF DEATH

02856

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County DorchesterCity or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 mos. 2 days

Hospital, institution, or street address where death occurred:

Eastern Shore State HospitalHow long in hospital or institution? 2 mos. 2 days

## 3. (a) FULL NAME

Clarence Howard

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Crisfield  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

3. (b) Social Security Number  
unknown4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced6. (b) Name of husband or wife Daisy Early6. (c) If alive, give unknown years7. Birth date of deceased (mo., day, yr.) January 21 18798. AGE: Years 66 Months 2 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Somerset County, Maryland  
(Town, county, and state)10. Usual occupation Waterman

11. Industry or business \_\_\_\_\_

12. Name John H. Howard13. Birthplace Somerset Co. Maryland14. Maiden name Clara Miller15. Birthplace Somerset Co. Maryland16. Informant Hospital RecordsAddress Cambridge, Maryland17. 3/27/48 Date thereof \_\_\_\_\_  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Crisfield CemeteryLocation Crisfield Md18. Funeral director John A. BradshawAddress Crisfield Md19. 3/25/48 (Date rec'd by registrar)John Maciej G. M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 25 1945 at 9:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 23 1945 to March 25 1945and that I last saw him alive on March 24 1945

Immediate cause of death \_\_\_\_\_

Tubo-paresis

Due to \_\_\_\_\_

Syphilis

Due to \_\_\_\_\_

Other conditions Syphilitic aortitisChronic nephritis

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Chas. M. Bruns M. D. or other \_\_\_\_\_Address Cambridge, Md Date signed 3/25/48

## DURATION

unknownunknown

CERTIFICATE OF DEATH

RECEIVED  
APR 2 1945  
BUREAU V.8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

02857

## CERTIFICATE OF DEATH

Reg. Dist. No. 110

## 1. PLACE OF DEATH:

County DorchesterCity or town Vienna  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? several years

Hospital, institution, or street address where death occurred:

Jonck's Thicket

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Vienna  
(If outside city or town limits, write RURAL and give nearest town)Street No. Jonck's Thicket

(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Weeley Johnson

## 3. (b) Social Security Number

None

4. Sex

male

5. Color or race

col.

6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife Kate Jones (deceased)

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1875

8. AGE: Years Months Days If less than one day

69 9 6 hrs. min.

9. Birthplace

Maryland  
(Town, county, and state)

10. Usual occupation

laborer

11. Industry or business

farm

12. Name

No data

13. Birthplace

No data

14. Maiden name

No data

15. Birthplace

Wm O. Chester

16. Informant

Vienna Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof

March 24, 1945  
(month) (day) (year)

Cemetery or crematory

Stifford Cemetery

Location

Reids Grove, Maryland

18. Funeral director

F. F. Frampton and Son

Address

Federalburg, Maryland19. (Date rec'd by registrar) March 23, 1945

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1945 at 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19and that I last saw him alive on 19

Immediate cause of death

Chronic Myocarditis

DUE TO

several months

DUE TO

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. H. Shivers, Dep. Med. Exam.Address Cambridge, Md.Date signed Mar. 24, 1945

M. D. or other

140

10850

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

DATE OF DEATH

RECEIVED

APR 5 1945

BUREAU OF

2



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1970

02858

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County Dorchester  
 City or town Cambridge Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 44 yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State \_\_\_\_\_ County \_\_\_\_\_  
 City or town \_\_\_\_\_  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Alex A. Slight

## 3. (b) Social Security Number

4. Sex male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Connie Slight  
 6. (c) If alive, give age 168 years  
 7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 60 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cambridge A.S.D.  
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Alex Slight

13. Birthplace md

14. Maiden name don't know

15. Birthplace md

16. Informant William Ward

Address Cambridge Md.

17. Burial Date thereof April 3 / 45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery Bethel

Location Cambridge Md

18. Funeral director Lewis H. Baggett

Address Cambridge Md

4-3 - 19 45 John Macph md

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 31 19 45 at 1:30 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 19 45 to March 30 19 45 and that I last saw him alive on March 30 19 45.  
 Immediate cause of death Brewna

	DURATION
Due to <u>Chronic nephritis</u>	<u>3 yrs</u>
Due to <u>Arteriosclerosis</u>	<u>10 yrs</u>
Other conditions <u>Hypertension &amp; old hemiplegia</u>	<u>3 yrs</u>
<u>Catastrophs</u>	<u>3 yrs</u>

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Alfred Bunker Md M. D. or other  
 Address 1021 K St, Cambridge Md Date signed 4-3-45

RECEIVED  
APR 9 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 588

02859

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County DorchesterCity or town Christ Rock Cambridge Road 1  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge Road 1  
(If outside city or town limits, write RURAL and give nearest town)Street No. (Christ Rock)  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Frederick Cyrus Marine

## 3.(b) Social Security Number

4. Sex

male

5. Color or race

colored

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

May 13 1935

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

9929

hrs.

min.

9. Birthplace Christ Rock Cambridge Md R 1

(Town, county, and state)

10. Usual occupation school child

11. Industry or business

FATHER

12. Name

Charles Marine

13. Birthplace

Dorchester Co Md

MOTHER

14. Maiden name

Annie Jolley

15. Birthplace

Dorchester Co Md

16. Informant

Charles MarineAddress Cambridge Md Road 1

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof March 14 1945  
(month) (day) (year)

Cemetery or crematory

Cemetery

Location

Christ Rock Md

18. Funeral director

Louis Beynon

Address

Cambridge Md

19.

3-14-45  
(Date rec'd by registrar)

19.

John M. J. M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945, at 11:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 13 1945, to March 11 1945;and that I last saw him alive on March 11 1945.

Immediate cause of death

Acute Rheumatic FeverAcute EndocarditisDue to Acute Rheumatic Fever

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Carroll M. St. Clair M.D.

M. D. or other

Address

Prattville AlaDate signed 3-13-45

MANHATTAN STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAR 19 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 308

02860

## CERTIFICATE OF DEATH

Reg. Dist. No. 11C

## 1. PLACE OF DEATH:

County... Dorchester CountyCity or town... Cambridge, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?... 3 monthsHospital, institution, or street address where death occurred:  
E.S.S.H., Cambridge, Md.How long in hospital or institution?... 3 mos.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... SomersetCity or town... Eden  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2(a) If veteran, name war .....

## 3. (a) FULL NAME

HERMAN EDWARD MARSHALL

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married6. (b) Name of husband or wife... Corbett Ella Stanley (Alice Dryden)6. (c) If alive, give age... 58 years7. Birth date of deceased (mo., day, yr.) June 6, 18868. AGE: Years Months Days If less than one day  
58 9 26 .....hrs. ....min.9. Birthplace... Somerset County  
(Town, county, and state)10. Usual occupation... Farmer

11. Industry or business .....

12. Name... Edward Marshall13. Birthplace Somerset County, Maryland14. Maiden name... Eleanor Cutlin

15. Birthplace .....

16. Informant... Hospital Records

Address .....

17. Burial Date thereof... March 14-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Baychut CemeteryLocation... Princess Anne, Md.18. Funeral director... Hollony & Co. Walter R. HollonyAddress... Salisbury, Maryland19. 3/13/45 19 45 John Mace Jr. Md  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... March 11 1945 at 8:50 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Jan. 24, 1945 19... to March 11 1945and that I last saw him alive on March 11 1945Immediate cause of death... Cardiac FailureDURATION  
3 daysDue to... Tabo-paresis7Due to... Syphilis, central nervous system?Other conditions... Chronic Myocarditis  
(Include pregnancy within 3 months of death)Many years

Major findings of operations... Date of op. ....

Autopsy results...  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE... Quint B. Bunsome  
M. D. or otherAddress... E.S.S.H., Cambridge, Md. Date signed... 3-11-45

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

WILLIAM HENRY LADD

RECEIVED  
MAR 19 1945  
BUREAU V.S.

RECEIVED MAR 19 1945

9



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

02861

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County DorchesterCity or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr 10 mos.

Hospital, institution, or street address where death occurred:

E.S.S.H., Cambridge, Md.How long in hospital or institution? 1 yr 10 mos.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)Street No. 305 Willis Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

J. EDWARD MARSHALL

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Edith F. Marshall6. (c) If alive, give age 49 years7. Birth date of deceased (mo., day, yr.) February 22, 18638. AGE: Years Months Days If less than one day  
82 22 hrs. min.9. Birthplace Cambridge, Maryland  
(Town, county, and state)10. Usual occupation Janitor

11. Industry or business

12. Name Thomas R. Marshall13. Birthplace Dorchester County, Md.14. Maiden name Margaret A. Hubbard15. Birthplace Dorchester Co., Maryland.16. Informant Hospital RecordsAddress Cambridge, Md.17. Burial  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director Kenneth R. ThomasAddress Cambridge, Md.19. 3-17-45 John MacCallister, M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 19 45 at 5:20 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 45, to Mar. 16 19 45, and that I last saw him alive on March 16 19 45.

Immediate cause of death

Cardiac Failure

DURATION

1 moDue to Generalized ArteriosclerosisArteriosclerotic Cardio-vascular diseaseDue to SenilityOther conditions Senile psychosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Ralph S. Chervin, M.D. M. D. or otherAddress E.S.S.H., Cambridge, Md. Date signed 3.16.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *RE*

## CERTIFICATE OF DEATH

02862

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County DorchesterCity or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 65 Years

Hospital, institution, or street address where death occurred:

120 Vue de leau St.How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)Street No. 120 Vue de leau St.  
(If rural, give LOCATION)2(a) If veteran, name war -

## 3. (a) FULL NAME

Frederick E. Meekins

## 3. (b) Social Security Number

-

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Verona Allen Meekins6. (c) If alive, give age 69 years7. Birth date of deceased (mo., day, yr.) Dec. 30, 1873.

8. AGE: Years Months Days If less than one day

71213hrs. min.9. Birthplace Cambridge, Dor. Co., Maryland  
(Town, county, and state)10. Usual occupation Merchant11. Industry or business Confectionery12. Name William H. Meekins13. Birthplace Maryland14. Maiden name Martha Meekins15. Birthplace Maryland.16. Informant Mrs. Fred. E. MeekinsAddress Cambridge, Maryland.17. Burial Date thereof Mar. 15, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cambridge CemeteryLocation Cambridge, Maryland.18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.19. 3-17- 19 45 John Mace Jr. md  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 19 45, at 3: A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 9<sup>th</sup> 19 45, to March 12<sup>th</sup> 19 45and that I last saw h. in alive on March 11, 19 45

Immediate cause of death

DURATION

6 ma 3 daysDue to Brain malignancy 1<sup>st</sup> theProstate gland with metastases.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. O. Meredith M. D. or otherAddress Cambridge, Maryland Date signed March 12, 1945

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REBURIAL

PLACE OF REBURIAL

DATE OF RECREMATION

PLACE OF RECREMATION

RECEIVED

MAR 19 1945

BUREAU U.S.

RECEIVED MAR 19 1945

9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 737

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH: **Dorchester**  
 County.....  
 City or town..... **Taylors Island**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... **entire life**  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... **Maryland** ..... County..... **Dorchester**  
 City or town..... **Taylors Island**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... **none** ..... **Rural**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... **none**

3.(a) FULL NAME  
**Samuel W. Moore**

3.(b) Social Security Number  
**none**

4. Sex **Male** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Married**  
 6.(b) Name of husband or wife..... **Elizabeth Jarrett**  
 6.(c) If alive, give age..... **70** ..... years  
 7. Birth date of deceased (mo., day, yr.) **September 25, 1873**  
 8. AGE: Years **71** Months **5** Days **28** If less than one day  
 ..... hrs. .... min.

9. Birthplace..... **Taylors Island, Md.**  
 (Town, county, and state)  
 10. Usual occupation..... **Farm Laborer**  
 11. Industry or business

FATHER 12. Name..... **Joseph S. Moore**  
 13. Birthplace..... **Dor. Co.**  
 MOTHER 14. Maiden name..... **Sarah Ann Lecompte**  
 15. Birthplace..... **Dor. Co.**

16. Informant..... **Mrs. Elizabeth J. Moore**  
 Address..... **Taylors Island, Md.**

17. **Burial** Date thereof..... **March 25, 1945**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery..... **Bethlehem M.E.**  
 Location..... **Taylors Island, Md.**  
**Kenneth R. Thomas**  
 18. Funeral director  
 Address..... **Cambridge, Md.**

19. **3-24-** **45** **John J. Mandy**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **March 23,** 19**45** at **5:00 A**  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 19**44** to **Mar. 23** 19**45**  
 and that I last saw him alive on **March 22** 19**45**

Immediate cause of death.....  
**Chronic Myocarditis**  
 Due to.....  
**Arterio-sclerosis**  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?

SIGNATURE..... **Dr. H. Spriner, M.D.**  
 M. D. or other  
 Address..... **Cambridge - Md.** Date signed..... **Mar. 24/45**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 882

## CERTIFICATE OF DEATH

Reg. Dist. No. 112

02864

## 1. PLACE OF DEATH:

County DorchesterCity or town Cambridge R.F.D. #2  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Home

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge (Rural)  
(If outside city or town limits, write RURAL and give nearest town)Street No. R.F.D. #2  
(If rural, give LOCATION)2. (a) If veteran, name war X

## 3. (a) FULL NAME

THOMAS HENRY MURPHY

## 3. (b) Social Security Number

X

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Sadie Wall Murphy.6. (c) If alive, give age 70 years7. Birth date of deceased (mo., day, yr.) 1/17/1864

8. AGE: Years Months Days If less than one day

81 1 15 hrs. min.9. Birthplace (Church Creek, Maryland)  
(Town, county, and state)10. Usual occupation Farmer (Dirt)11. Industry or business RetiredFATHER 12. Name James M. Murphy13. Birthplace Md.MOTHER 14. Maiden name Jemims Horseman15. Birthplace Md.16. Informant Mrs Sadie W. Murphy.Address Cambridge R.F.D. #2 Md.Burial 3/4/45

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Jasper WilleyLocation Cambridge R.F.D #2 Md.18. Funeral director LeCompte Funeral ServiceAddress Cambridge, Md.19. March 3 1945 Mrs R. L. Wright.

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1945, at 4 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 8" 1945, to March 1" 1945, and that I last saw him alive on March 1" 1945.Immediate cause of death Apoplexy

DURATION

Due to Cerebral haemorrhage

Due to

Other conditions Arterio-sclerosis.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury (Injured at work?)

23. Edward E. Lamkin.

Edward E. Lamkin, M.D. Vienna, Md.

Address

Data signed



RECEIVED  
APR 5 1945  
BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19720

02865

## CERTIFICATE OF DEATH

Reg. Dist. No. 110

## 1. PLACE OF DEATH:

County Dorchester  
 City or town Hurlock - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 60 years  
 Hospital, institution, or street address where death occurred:  
Berulah  
 How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Dorchester  
 City or town Hurlock - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Berulah  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war -

## 3. (a) FULL NAME

George W. Neal

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Sarah R. Neal  
 6.(c) If alive, give age - years  
 7. Birth date of deceased (mo., day, yr.) September 1, 1864  
 8. AGE: Years 80 Months 6 Days 23 It less than one day - hrs. - min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation Retired Farmer  
 11. Industry or business Farm  
 12. Name Cyrus Neal  
 13. Birthplace Ireland  
 14. Maiden name No data available  
 15. Birthplace -

16. Informant Mrs. Harvey J. Brodes  
 Address Hurlock, Maryland, R.F.D.  
 17. Burial Date thereof March 27, 1945  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory McKendree Cemetery  
 Location Rhodesdale, Maryland  
 18. Funeral director J. J. Frankham and Son  
 Address Federalburg, Maryland  
 19. March 26 45 - Charles Hastings  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 19 45, at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 24 19 45 to Mar 24 19 45  
 and that I last saw him alive on Mar 24 19 45

Immediate cause of death Uremia

DURATION

1 dayDue to Chronic InterstitialDue to Nephritis10 MOOther conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE W. E. Harrison M. D. or otherAddress Federalburg, Md Date signed 3/26/45

RECEIVED  
APR 5 1945  
BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

02866

## CERTIFICATE OF DEATH

Reg. Dist. No. 111

### 1. PLACE OF DEATH:

County Dorchester  
City or town East New Market  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days) none  
Stay in this community (yrs., or mos., or days) 2 years

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County Kent  
City or town Viola Ward No.  
(If outside city or town limits, write RURAL NEAR and give town)

Street No.  
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

### 3. (a) FULL NAME

Hettie Weller Peter

### 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow

8 (b) Name of husband or wife

6 (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Jan 18th 1862

8. AGE: Years 83 Months 2 Days 2 hrs. \_\_\_\_\_ min.

9. Birthplace Pikeville, Pa.  
(Town, county, and state)

10. Usual occupation Housewife

### 11. Industry or business

12. Name John E. Hottel

13. Birthplace Oley Township-Berks Co. Pa

14. Maiden name Esther W. Hottel

15. Birthplace Oley Township-Berks Co. Pa

16. Informant R.D. Peter

Address Horistown, Rd #1 Pa.

17. Burial Date thereof Mar 24-1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Odd Fellows

Location Camden, Del

18. Funeral director Wm A. Barry

Address Felton, Del.

19. March 22, 1945 Elizabeth C. Smith  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1945, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1943, to March 22 1945, and that I last saw her alive on March 22 1945

Immediate cause of death Coronary Ischemic Heart Disease DURATION 2 years

Due to Chronic Myocarditis 10 years

Due to Coronary Occlusion 2 months

Other conditions Atherosclerosis Hypertension 14 years

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy None done

22. VIOLENCE: if death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Judy D. Parnell M. D. or other

Address Frederick, Md 21701 Date signed 3/21/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PHYSICIAN  
Please underline the cause to which death should be charged statistically.

RECEIVED  
APR 5 1945  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

## CERTIFICATE OF DEATH

Reg. Diat. No. 02867 116

<b>1. PLACE OF DEATH:</b> County..... <u>Dorchester</u> City or town..... <u>Cambridge</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>1 year</u> Hospital, institution, or street address where death occurred: <u>106 Race St.</u> How long in hospital or institution?.....				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Dorchester</u> City or town..... <u>Cambridge</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>106 Race</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
<b>3. (a) FULL NAME</b> <u>Harry P. Plummer</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>male</u>				<b>5. Color or race</b> <u>white</u>			
<b>6. (a) Single, married, widowed, or divorced</b> <u>divorced</u>				<b>MEDICAL CERTIFICATION</b>			
<b>8. (b) Name of husband or wife</b> <u>Lily Lauch</u>				<b>20. DATE OF DEATH</b> <u>March 18</u> 19 <u>45</u> , at <u>9 A.</u> M.			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>June 25, 1901</u>				<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>X</u> 19....., to <u>X</u> 19..... and that I last saw h. <u>X</u> alive on <u>X</u> 19..... Immediate cause of death..... <u>Disease of the</u> <u>Coronary Arteries</u> Due to..... <u>X</u> Due to..... <u>X</u> Other conditions..... <u>X</u> (Include pregnancy within 3 months of death) Major findings of operations..... <u>X</u> .....Date of op. .... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically. <b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where)?..... Means of Injury..... Injured at work?.....			
<b>8. AGE:</b> Years <u>43</u> Months <u>8</u> Days <u>23</u> If less than one day <u>X</u> hrs. .... min.				<b>DURATION</b> <u>several</u> <u>months</u>			
<b>B. Birthplace</b> <u>Boston, Maryland</u> (Town, county, and state)							
<b>10. Usual occupation</b> <u>Produce Dealer</u>							
<b>11. Industry or business</b> <u>" "</u>							
<b>FATHER</b> 12. Name..... <u>James J. Plummer</u> 13. Birthplace..... <u>Maryland</u>							
<b>MOTHER</b> 14. Maiden name..... <u>Lily Jester</u> 15. Birthplace..... <u>Maryland</u>							
<b>18. Informant</b> <u>Mrs. Elizabeth Elliott (sister)</u> Address..... <u>Secretary, Maryland.</u>							
<b>17. (Burial, cremation, or removal. Which?)</b> <u>Burial</u> Date thereof..... <u>Mar 21, 45</u> (month) (day) (year) Cemetery or crematory..... <u>Spring Hill</u> Location..... <u>Easton, Md.</u>							
<b>18. Funeral director</b> <u>Wm. E. Stevens</u> Address..... <u>Easton, Md.</u>							
<b>19. (Date rec'd by registrar)</b> <u>3-21-45</u> 19 <u>45</u> <u>John MacFarland</u> Registrar				<b>23. SIGNATURE</b> <u>Dr. R. Shriver, Def. Med. Exam.</u> M. D. or other Address..... <u>Cambridge, Md.</u> Date signed..... <u>Mar. 18/45</u>			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

02868

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County DorchesterCity or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? May 27, 1943

Hospital, institution, or street address where death occurred:

Eastern Shore State HospitalHow long in hospital or institution? May 27, 1943

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Greensboro  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JAMES ABNER SABIN

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widower6. (b) Name of husband or wife Jennie Markler

## 7. Birth date of

deceased (mo., day, yr.)

September 7, 1852

6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

92628

.....hrs. ....min.

9. Birthplace Blossburg, Tioga County, Pa.  
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

FATHER  
MOTHER12. Name Not known

13. Birthplace

14. Maiden name Not known

15. Birthplace

16. Informant Hospital records

Address

17. Burial  
(Burial, cremation, or removal, Which?)Date thereof March 6, 1945  
(month) (day) (year)Cemetery or crematory GreensboroLocation Greensboro Twp.18. Funeral director Raymond B. RawlingsAddress Greensboro Md.19. 3/31  
(Date rec'd by Registrar)19. 45 John M. J. M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1945 19\_\_\_\_\_, at 1:05 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Jan. 1, 1945 19\_\_\_\_\_, to March 3, 1945 19\_\_\_\_\_,and that I last saw him alive on March 3, 1945 19\_\_\_\_\_.

Immediate cause of death

Coronary thrombosis

DURATION

1 mo.Due to Generalized arteriosclerosis

Due to

Other conditions Senile psychosis - simple  
deterioration

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE Ralph S. Chenoweth M.D.  
M. D. or otherAddress E. S. S. H., Cambridge, Md. Date signed 3/31/45



RECEIVED

CERTIFICATE OF DEATH

RECEIVED

MAR 6 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 467

## CERTIFICATE OF DEATH

02869

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County DorchesterCity or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 YEARS

Hospital, institution, or street address where death occurred:

Cambridge Maryland Hospital Inc.How long in hospital or institution? 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Cambridge  
(If outside city or town limits, write RURAL and give nearest town)Street No. Blagow Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Philip Scher

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife ELIZABETH HEIGH(DECEASED)

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 2, 1862

8. AGE: Years Months Days If less than one day

825-hrs.min.9. Birthplace Washington D.C.

(Town, county, and state)

10. Usual occupation STRUCTURAL IRON WORKER

11. Industry or business

12. Name Frank Scher13. Birthplace Germany14. Maiden name NOT KNOWN

15. Birthplace

16. Informant Hospital Record

Address

17. BURIAL Date thereof MARCH 5 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory DORCHESTER MEMORIAL PARKLocation CAMBRIDGE MARYLAND18. Funeral director LECOMPT'S FUNERAL SER.Address CAMBRIDGE MARYLAND19. 3/3/45 John Manaford  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH February March 2 19 45 at 9:45 A.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 22 19 45 to March 2 19 45and that I last saw him alive on March 2 19 45

Immediate cause of death

Carcinoma of the stomach

## DURATION

Unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. O. Meredith, M.D.  
M. D. or other

Address Date signed

RECEIVED

MAR 6 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of MARYLAND STATE DEPARTMENT OF HEALTH  
usual residence of deceased is 2411 N. Charles St., Baltimore (32)

02870

Reg. Dist. No. 116

shown on  
FILM No. G 95 JUN 13 1945

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County... Golden Hill  
City or town... Dorchester County  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death... Life time  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Dorchester

City or town... Church Creek  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Arvel Travers

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Colored Single

6. (b) Name of husband or wife

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 9 1900

8. AGE: Years 44 Months 2 Days 26 It less than one day ..... hrs. .... min.

9. Birthplace Golden Hill, Md.  
(Town, county, and state)

10. Usual occupation... Labor

11. Industry or business

12. Name... John Travers

13. Birthplace... Maryland

14. Maiden name... Rachel Todd

15. Birthplace... Maryland

16. Informant... Guennie Molock

Address... 4233 Ashland Ave Bal

17. Burial Date thereof... Mar 11 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Winfield Cemetery

Location... Golden Hill

18. Funeral director... H. B. Harrison

Address... 201 W. Wash St

19. 3/10 19 45 John M. M. M. M.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... March 5 19 45 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5 19 45 to March 3 19 45

and that I last saw him alive on March 3 19 45

Immediate cause of death... Coronary Thrombosis

Due to... Chronic Cardiac Vascular Disease with Myocardial Infarction

Due to... 5 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature... Chas. E. Deuster

Address... Cambridge Md

Date signed... 3-10-45

RECEIVED

MAR 19 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

02871

## I. PLACE OF DEATH:

County... Dorchester  
 City or town... Cambridge, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... 2 yrs  
 Hospital, institution, or street address where death occurred:  
E.S.S.H., Cambridge, Maryland.  
 How long in hospital or institution?... 2 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Dorchester  
 City or town... Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... West End Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

MARY ANN TRAVERS

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FEMALE

WHITE

WIDOW

6.(b) Name of husband or wife... Charles M. Travers

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) February 18, 18708. AGE: Years Months Days It less than one day  
75 - 14 hrs. min.9. Birthplace... Fishing Creek, Dorchester Co.  
 (Town, county, and state)10. Usual occupation... Housewife

11. Industry or business

12. Name... Benjamin Lewis13. Birthplace... Dorchester County, Maryland14. Maiden name... Not known15. Birthplace... Howard County, Maryland.16. Informant... Lloyd H. TraversAddress... Cambridge Md.17. Burial Date thereof... 3/6/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Hope M.E. ChurchyardLocation... Fishing Creek Md.18. Funeral director... Remond R. ThomasAddress... Cambridge, Md.19. 3/5/45 - John M. M. M.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... March 4, 1945 at... 3:55A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 1, 1945 to March 4, 1945  
 and that I last saw her alive on March 3, 1945Immediate cause of death... Cardiac and Respiratory Failure DURATION 2 daysDue to... Arteriosclerotic Cardio-vascular disease - - Senility

Due to.....

Other conditions... Senile Psychosis, Simple deterioration  
 (Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Joseph S. Bennett MD  
 M. D. or otherAddress... E.S.S.H., Cambridge, Md. Date signed... 3/4/45



RECEIVED BY THE CHIEF OF BUREAU

RECEIVED BY THE CHIEF OF BUREAU

RECEIVED BY THE CHIEF OF BUREAU

RECEIVED

MAR 6 1945

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (822)

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

02872

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Cumtury Md  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Borchol  
 City or town Cumtury  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Baily Rd  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Alex Subman

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife Priscilla Subman

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 14 1962

8. AGE: Years 83 Months 0 Days 24 If less than one day  
 Hrs. min.

9. Birthplace Baltimore Co Md  
(Town, county, and state)10. Usual occupation Laborman

11. Industry or business

12. Name John Subman13. Birthplace Baltimore Co Md14. Maiden name Carolin Shawberry15. Birthplace Maryland16. Informant Carolin SubmanAddress Cordtlan Md17. (Burial, cremation, or removal. Which?) Date thereof March 11 1945  
(month) (day) (year)Cemetery or crematory CordtlanLocation New Cumtury18. Funeral director James A. BayneAddress Cumtury Md19. 3/10/45 20. John Mace Jr. Md  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1945 at 2:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 7 1945 to March 8 1945  
 and that I last saw him alive on March 7 1945

Immediate cause of death

Cerebral HemorrhageDue to Hypertension

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Carroll M. Steele MD

M. D. or other

Address Greenfield Ch Date signed 3-10-45

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH, MASSACHUSETTS

RECEIVED

RECEIVED  
MAR 19 1945  
BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 136

02873

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

## 1. PLACE OF DEATH:

County Dorchester  
 City or town Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 Months (Recent)  
 Hospital, institution, or street address where death occurred:  
100 Gay St.  
 How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester  
 City or town Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 100 Gay St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war -

## 3. (a) FULL NAME

John Milford Vane

## 3. (b) Social Security Number

-

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Divorced

## 6. (b) Name of husband or wife

-

8. (c) If alive, give age - years

## 7. Birth date of

deceased (mo., day, yr.)

July 1, 1901.

## 8. AGE:

Years

Months

Days

If less than one day

43

8

21

hrs.

min.

9. Birthplace Cambridge, Dor. Co., Maryland.

(Town, county, and state)

## 10. Usual occupation

Clerical

## 11. Industry or business

FATHER

## 12. Name

John N. Vane

## 13. Birthplace

Maryland.

MOTHER

## 14. Maiden name

Annie Oeh

## 15. Birthplace

Maryland

16. Informant Mrs. John N. VaneAddress Gay St., Cambridge, Maryland,

## 17. Burial (Burial, cremation, or removal. Which?)

Date thereof Mar. 24, 1945  
(month) (day) (year)Cemetery or crematory Dorchester Memorial ParkLocation Cambridge, Maryland.18. Funeral director LeCompte's Funeral ServiceAddress Cambridge, Maryland.19. 3-23-45 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 22, 1945 at 5: P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 3 - 1945 to March 31 - 1945  
and that I last saw him alive on March 31 - 1945

Immediate cause of death

Pulmonary Tuberculosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of -Where did injury occur? -  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -

23. SIGNATURE

John Stealy  
Cambridge, Md.

M. D. or other

Address Cambridge, Md. Date signed 3/24-1945

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians' please write the causes of death clearly and legibly.